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INSTRUCTIONS to PHYSICIANS and CLINIC WORKERS

Case History and Examination---Form 38

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF WELFARE
BUREAU OF MENTAL HEALTH
HARRISBURG

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To emphasize the necessity for a more detailed and complete physical and mental examination, a new form 38 has been prepared. The headings have been gathered together from material representing the experience of a large number of workers over a long period of time. The points emphasized are those which stress the interrelation of the commonly associated physical and mental defects and disorders. The arrangement is such as to follow a definite routine easily learned and to result in a uniform system of records from which material of value may be compiled. In order to make this material accessible, physicians and nurses will fill in, with an appropriate entry, every blank space, making such entries only on the basis of careful examination and personal observation or authenticated information.

The completed form should give to the reader a definite mental picture of the physical and mental characteristics and reactions of the patient, even though the reader had never seen the patient. Certain structural and developmental abnormalities which are frequently found associated with mental defect, faulty behavior reactions and neurological disease are emphasized, even though the data would not appear significant when taken alone. The examiner and social worker are held responsible for the accuracy and completeness of the data furnished. A check of the adequacy of the examinations and histories and of the follow-up work in each clinic will be undertaken periodically by a representative of the Bureau of Mental Health.

Examinations at the clinics will be made on the basis of appointment only unless one or more of the appointment hours is vacant. Examinations of urgent and emergency cases will, however, always be undertaken regardless of appointments if the urgency is clearly shown. In order to secure a full number of appointments for the examination hours, it is suggested that the physicians and social agencies of the community be advised by telephone or letter a few days in advance of the clinic date, by the clinic secretary. It will also be found advisable to spread knowledge of the clinic in the community by having a short notice of the purpose and aims inserted in the local newspaper a few days prior to the clinic date by the secretary.

The social worker or person at whose request the appointment is made will be held responsible for the appearance of the patient promptly at the hour set. The social worker who will follow up the case will be held responsible for the patient's cleanliness and freedom from contagious or epidemic disease. The patient must

be accompanied by one or more adult members of the family who can supplement the information already obtained, if necessary.

The blank spaces heading the first page are self explanatory. They call for information of a statistical nature which is necessary for the completion of records at the central office. Under NAME the last or family name should be placed first. The address should be the mail address of the patient and include the street and number or R. F. D. route. The name and address of the person or organization at whose request the examination is made follows. The entry under PROBLEM should state clearly, briefly and simply the various ways in which the patient does not conform to accepted standards. The date and place of birth should be verified if possible The RACE should conform to the requirements of the Statistical Manual of the National Committee for Mental Hygiene which lists the following:

African (black)	German	Romanian
American Indian	Greek	Scandanavian
Armenian	Hebrew	Scotch
Bulgarian	Irish	Slavic
Chinese	Italian	Spanish
Cuban	Japanese	Syrian
Dutch & Flemish	Lithuanian	Turkish
East Indian	Magyar	Welsh
English	Mexican	West Indian
Finnish	Pacific Islander	Mixed
French	Portugese	

The category "mixed" includes all mixtures of races, i.e., all patients whose ancestors were of two or more races.

MARITAL CONDITIONS includes only five subdivisions: single, married, widowed, divorced and separated. CHILDREN refers to the children of the patient under consideration. The extent of the school attendance with the age of completion should be entered in the appropriate space, as should also the OCCUPATION, the CHURCH affiliation, the DURATION OF THE PRESENT SYMPTOMS and the INSTITUTION RESIDENCE. In case a patient has resided as a patient in a public or private institution, the name and address of the institution and the duration of residence should be recorded, and this must be verified by the clinic worker by correspondence with the institution at which time a copy or summary of the institution records is to be obtained and filed with the case history.

Page 2, and the upper half of page 3, gives an outline of the barest essentials which must be investigated and recorded as history for every patient by the nurse or social worker. The importance of the points touched is obvious. The heredity is tabulated for ease and in order that nothing is omitted. The full name of each relative should be given. (The maiden name of the mother and both grandmothers should be given for the reason that in widely separated communities we frequently find related families presenting the same neurological or mental abnormalities.) In place of DATE OF BIRTH the age, if living, or age at death may be given. The first line of page 2 gives the conditions to be especially noted in completing the last two columns. It is suggested that in the first column under RELATIONSHIP sufficient space exists to record the school

grade attained by each brother and sister and by the father, mother and husband or wife.

For ease of obtaining history, the personal history below is subdivided into infancy, childhood, adolescence and present illness. The importance of every point cataloged cannot be sufficiently stressed. It is a well-known fact that premature babies, prolonged labor, instrumental delivery, birth injuries and over-size are of the utmost importance in determining certain neurological and mental conditions, particularly spastic paralysis and mental defect because they subject the brain of the child and the cerebral blood vessels to trauma at a time when the skull is so soft as to be readily deformed and to afford little protection to the delicate structures beneath. Reasons might be multiplied to show that every bit of information asked for in these succeeding spaces is equally important if we are to evaluate the disability of the patient, estimate the chances of restoration, and prescribe therapeutic measures.

Under CHILDHOOD AND ADOLESCENCE detailed questions are not asked but the same general leads may be followed as are given above under INFANCY. The HISTORY OF PRESENT ILLNESS should be given in full from the earliest reeognized symptom, giving date and manner of onset, in detail; chronologic sequence, carrying the patient through the successive stages of his difficulty. right up to the present date, omitting nothing which might have a bearing on the condition; and finally giving dates and brief statements of previous mental or nervous disease, stating what things in the eondition or environment make it imperative that help be given at this time rather than earlier or later. The NAME and RELATIONSHIP to the patient of the person from whom the information was obtained are a necessary part of the record. From this point, however, no entries are to be made except by the psychologist who will record here her observations and the results of the psychometrie tests.

The outline for the MEDICAL EXAMINER on page one is arranged for a complete and detailed tabulation of the patients' handieaps, in order that the corrective measures, listed under RECOMMENDATIONS below, may represent a systematic attempt to reduce to a minimum the burden which the patient must carry. Almost without exception reduction of the physical handicaps is followed closely by improvement in mental and nervous symptoms and better edueability or trainability. In this connection it may be emphasized that the physical examination should be as comprehensive as the ordinary periodic health examination, except that the laboratory procedures may be limited to those actually indicated. This will enable the physician to prescribe more fully and understandingly and cover the patients' needs from the physical as well as the neuropsyehiatrie standpoint.

Several points must be stressed here: It is remarkable how frequently eareful and detailed physical examination will disclose defects where previous examinations have been recorded as "negative." This oversight, applied to school medical inspection, is sufficient to have exeited eomment on the part of educators. The omissions seem to be most marked in the important fields of nutrition, of posture, of vision and of hearing, especially where the latter is

associated with middle ear disease or obstruction of the external auditory canals. (When one considers the marked mental retardation that may result from sensory deprivation, the importance of corrective measures to restore vision and hearing becomes apparent). Omissions have also been noted in nose and throat conditions, phimosis, minor joint affections, and in muscular atrophy or dystrophy of mild degree. In the cases of delinquency and behaviour problems, approximately ninety per cent are found to present physical defects of the nature mentioned above, frequently associated with mental defect. In addition to this, the higher grades of mental defect are commonly, and the lower grades constantly, associated with physical defect. Another point frequently overlooked as a factor in the efficacy of treatment is a feeling of confidence in the physician. In general this is the natural reaction of the patient to a careful and detailed physical examination. There is no easier or more certain method of gaining the patients' confidence, and this makes the mental examination much more effective and less difficult.

The recommendations entered below should be complete from the physical, neuropsychiatric, social and educational standpoints. These recommendations should comprise all the corrective measures required to restore the individual to as nearly normal a condition as possible. Under STATUS the lines are numbered in order that check marks or circles may be made before each line which contains an entry indicating defect or disease. This facilitates the consolidation of positive findings below and insures that none will be omitted in the final summary. In this way the physical and neurological examinations are presented in outline capable of expansion in any direction as the findings indicate in any given case.

A check must be made against any laboratory procedures necessary for the completion of the investigation and space for this is provided in line 26. It will facilitate the work of the clinic secretary and the work of the central office if the physical findings entered in the next line are recorded in the order in which they appear in the outline above, and also if they are numbered serially. The physical recommendations should embrace such corrective measures as will give the maximum restoration for each condition found. The recommendation for correction should be made regardless of whether it appears feasible to apply the correction at once or whether correction will have to be deferred. The corrections recommended should also be numbered serially.

The MENTAL EXAMINATION recorded on page four must show evidence of inquiry into the various mental fields sufficient to confirm the mental diagnosis offered and to confirm or exclude the existance of mental disease. It is expected that diagnosis of mental deficiency will be made not exclusively on the results of the psychometric examination, but that confirmatory evidence will be offered in the mental examination of social or educational difficulties and delinquencies with the patient's own story of the reason or cause of each.

Where mental disease exists the examination should bring out not only the symptoms presented but the patient's reaction to the examination, the reasons he gives for his conduct, and a brief presentation of the differential diagnosis. The suggestions offered at

the left of the page will not be followed in every case, but where an adequate history of the patient's difficulties has been obtained on page three the examiner should use his own method of obtaining the story from the patient and draw his conclusions at the foot of the page.

In questions of delinquency and behaviour problems an attempt must be made to get at the underlying cause for the faulty reactions. This may require several interviews at successive clinics. An attempt must be made to answer the question "What circumstance or combination was responsible for the initiation of the faulty reaction, and why is it being continued?" Until the correct answer has been found the removal of the cause, which is an essential part of treatment, will be impossible.

When the mental examination has been completed the neuropsychiatric findings may be presented in the form of a definite diagnosis at the bottom of page one, and in the appropriate space below, the corrective measures which are advised. In formulating recommendations the aim should be to accomplish the utmost for the relief of the difficulty. Occasionally, however, it will be necessary to make a compromise in an acute situation or in one where the limitations of the family or community are evident. At times it is only in this way that the examiner may avoid antagonizing the family or community and gain their cooperation.